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AUTHOR Brown, Bertram S.
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ABSTRACT

Presented is a speech by Bertram Brown, director of the National Institute of Mental Health, on the effects of decreased federal funding of mental health research. Brown notes that there has been a 56% slash in the purchasing power of the research grant program when inflation is accounted for. It is suggested that causes of the dwindling support of mental health research include a widespread antiscience attitude, stigma against mental illness, and the failure of scientists to seek public and political support. The foremost priority is seen to be public support of mental health research needs. (DB)

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The Crisis in Mental Health Research

The following is a summary of a major address by Bertram S. Brown, M.D., Director of HEW's National Institute of Mental Health, at the 1976 Annual meeting of the American Psychiatric Association. The entire text is attached.

The purchasing power of the Federal dollar invested in research on mental illness has eroded to less than half of its value 10 years ago, to a level "threatening the survival" of the Nation's mental health research program, the Director of HEW's National Institute of Mental Health warned in a major address to the American Psychiatric Association.

Dr. Bertram S. Brown, the government's top-ranking psychiatrist, told members of the APA, holding their annual meeting in Miami Beach, May 13, that NIMH research monies are caught in a pincer of budget cutbacks and inflation.

He pointed out that since NIMH is the major source of support for all mental health research in the country, the Institute's decreased funding ability affects researchers in universities, hospitals, and research facilities throughout the country. Approximately two-thirds of the Institute's total current $96 million research budget goes to scientists outside government.

The impact of the cuts is being felt at a time when the "enormous yield" of earlier years' research is increasingly apparent, Brown said. Since the NIMH was created in 1946, scientists have advanced far in understanding basic brain and behavioral processes and have applied the new knowledge to the treatment, and, in some cases prevention, of such crippling mental disorders as depression.

Brown noted that the delivery of mental health services also has benefitted from the research base. He pointed out that since the early 1950's, the populations of State mental hospitals have been cut by more than half, primarily due to the fact that research has yielded effective new treatments that greatly reduce the amount of time many patients must be hospitalized.

These new treatments, he said, permit many patients who formerly would have been hospitalized to be served by community-based mental health centers. Such centers now make services available to localities where more than 87 million Americans live.

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Citing the extent of the budget decline, Brown compared NIMH support trends to those of other Federal biomedical research programs. Where the actual research dollars available to the mental health program have dropped by 7.6 percent over the past decade, the research budget of the government's National Institutes of Health has increased by 263 percent over the same period.

The hardest hit NIMH program has been research grants, where inflation and rapidly rising research costs compound the problem of declining budgets. The situation is getting worse, Brown said. The proposed 1977 HEW budget requests $60.1 million for the NIMH research grant program, an amount that is $20.6 million less than was allocated 10 years ago.

This $20 million, or 25 percent, cut in actual dollars translates to a 56 percent slash in the purchasing power of the research grant program when inflation is accounted for, Brown said.

One more potentially severe effect is that experienced researchers, unable to wait indefinitely for support, are turning to other pursuits, such as teaching. Younger scientists, in turn, lack excellent research training opportunities, foretelling a gap in the qualified research pool 10 and 20 years from now, Brown said.

Brown offered several explanations for the dwindling support of mental health research. One, he said, emanates from a more widespread anti-science attitude and is reflected in public fear of the increasing sophistication of psychiatric and psychological techniques.

Also, stigma against mental illness has not been wiped out, Brown said. "People will talk openly about a heart attack, or surgery for cancer, but still keep secret their depression or that of a family member.

"Mental health problems are for many fiction, a convenient rationalization for those who would pamper the 'morally decayed' or the 'ethically flawed' among us. If the goal of mental health research is rejected, so, too, is the mental health research community and the Federal institution that serves its purpose," Brown told the psychiatrists.

Another problem is that many persons oppose the expansion of mental health research into social issues, on the grounds that such research detracts from an emphasis on basic biological and behavioral research on the severe mental illnesses.

But Brown pointed out that NIMH research administrators must respond continually to social priorities determined from within the Institute as well as by the Congress.

"Much of the money now being funnelled toward social problems research is money that came available specifically for that purpose; thus the claim that these activities are eating from the biomedical and behavioral trough is arguable," he said.

Brown also questioned the failure of the scientists themselves to seek public and political support for their work.

"Many scientists remain naive about governmental processes, believing that an editorial in Science or a letter to their Congressman will prove effective" in engendering support for mental health research. "Few scientific groups work to their political advantage at a local level. Few know their local Congressman, or, more important, how to reach the constituent power base behind the Congressman, Brown said.

He urged that scientists communicate more freely with the public about the process and potential of their research.

"One hopeful development," Brown said, "is that citizen groups such as the 1 million member National Association for Mental Health that have been and are effective in engendering support for mental health services are now aware of the research crisis and have begun to put their efforts behind support of the research component of the National mental health effort."

"Our foremost need in an era of increasing competition for scarce research resources is public support. The public has to make a committed and informed decision as to whether or not it will support mental health research needs," Brown said.

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THE CRISIS IN MENTAL HEALTH RESEARCH

By

Bertram S. Brown, M.D.
Director
National Institute of Mental Health

Annual Meeting
American Psychiatric Association
Miami Beach, Florida
May 13, 1976

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THE CRISIS IN MENTAL HEALTH RESEARCH

I. INTRODUCTION

Thirty years ago this bicentennial July, President Harry Truman signed and approved Public Law 487, known commonly as the National Mental Health Act. That law, which created the National Institute of Mental Health, marked the beginning of the Federal Government's large scale support of research in mental health. The language of the legislation bears repeating today:

> The purpose of this act is the improvement of the mental health of the people of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; assisting and fostering such research activities by public and private agencies, and promoting the coordination of all such researches and activities and the useful application of their results; training personnel in matters relating to mental health; and developing, and assisting States in the use of, the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders.

While the Act called for the support of clinical training and some services, the emphasis on research was apparent. The legislation specifically authorized a variety of mechanisms for its support: intramural studies, research fellowships, and grants to institutions and individuals. A National Advisory Mental Health Council was created under the legislation to review and select projects that might make "valuable contributions to human knowledge with respect to the cause, prevention, or methods of diagnosis and treatment of psychiatric disorders."

Within forty-five days of the Act's implementation the first Council was convened--financed by a foundation grant, for the first appropriation to the new Institute would not be for another year--to discuss plans for the agency. Immediately, one crucial decision was made. On the recommendation of Council, Congress placed the yet to be chartered National Institute of Mental Health under the research oriented National Institutes of Health. The alternative would have been to situate the NIMH within the Bureau of State Services, an

understandable option in light of the new organization's service responsibilities. By agreeing to the NIH designation, Congress approved the notion that treatment of mental illness could be furthered most effectively by conducting and stimulating research. The die was cast; by 1955, the NIMH was spending nearly one-half of its total budget on research, a proportion that would remain stable for more than 15 years.

Under that initial mantle of support, and in later years despite the trend toward a reduction in support, the Institute's research effort has unquestionably produced an enormous yield. It has led to a substantial increase of information about the causes, treatment, and prevention of mental illness and about factors that foster mental health. In research facilities throughout the country and the world, NIMH scientists in disparate fields have sought and acquired knowledge that has touched and enhanced the lives of countless mentally ill people.

These research efforts have been undertaken not only to develop knowledge but to apply this knowledge. Our mental health service delivery capability depends ultimately on a tested, scientific ability to understand and deal with mental illness. Without the test of application, hard won basic and clinical knowledge withers.

In like manner, attempts to develop sophisticated and effective mental health professional resources falter when they lack the input and dynamism of new knowledge. That knowledge, in turn, will not be forthcoming in the absence of trained researchers and clinicians.

A mental health "effort" or a national "capability" is a tenuous enterprise, as the terms themselves imply. Without the research fiber--the woven strands of new knowledge that provide stability and direction to tangible service settings and staff--a solid network becomes a fragil web.

Today, the Nation's mental health research program stands on the brink of collapse. This paper provides the hard data and the personal observations which, taken together, lead to a single conclusion: The Nation's mental health research program faces a crisis threatening its survival as a force for public health. The crisis is born of a host of factors--fiscal, political, administrative, psychological, and social. It is not an unanticipated and explosive crisis but rather is a veiled and erosive amalgam of circumstances. It is a crisis that warrants our attention, analysis, and mobilization.

II. THE CRISIS UNFOLDS: 1967 - 1977

To fully understand the crisis confronting research today, one requires a perspective over time. One meaningful timeframe is the immediate past decade. In 1967, under a major Public Health Service reorganization, NIMH gained independent bureau status, autonomous and equal to the National Institutes of Health. Events that led up to and influenced this change, like events that followed, were staggered and cumulative. In order then to establish 1967 as a decisive point in the Institute's evolution, one must look back and compare it with the preceding decade - the 50's.

The Early Years

The research program of the young Institute, supported by Congress, Council, and the NIMH philosophy, grew steadily for a number of years. In 1950, research expenditures accounted for approximately 12 percent of the Institute's total budget. By 1955, research program growth could be described aptly as meteoric. Research expenditures that year totaled 45 percent of a $14 million dollar budget; 10 years later they represented 46 percent of a $186 million dollar budget.

Even as the boom years began, events were occuring that were to have a strong influence on the program more than 15 years in the future. In large part, these events can be described in terms of three major pieces of legislation that, in a positive manner, extended the authorization of the original National Mental Health Act and moved the Institute toward the 1967 turning point.

The first of these was the Mental Health Study Act of 1955; it led to formation of the Joint Commission on Mental Illness and Health whose charge was to conduct an extensive analysis and evaluation of the country's mental health needs. The Commission's comprehensive final Report, Action for Mental Health, provided the major impetus and background to President Kennedy's National Mental Health Program.

The second piece of legislation was the Health Amendments Act of 1956. Title V of that legislation authorized stepped up activity in the areas of treatment and rehabilitation of the mentally ill, primarily through the mechanisms of technical assistance and hospital improvement grants. A critical feature of the technical assistance

effort was the emphasis it afforded specific topical areas such as drug addiction and alcoholism. This activity would prove, in time, to be a precursor of more formal NIMH expansion into the social problems area.

Lastly, the Community Mental Health Centers Act of 1963 initiated a new era of Federal involvement in support of mental health services. The addition of the community mental health centers program so increased the NIMH's responsibilities and budget--an increase of $150 million for the first three years of that program--that changes were required both within the Institute and in the Institute's relation's with other agencies. In 1967 all of these influences converged.

1967: The Turn About Begins

Creation of the community mental health centers program notwithstanding, prior to 1967, the NIMH had grown at a faster rate than any other Institute of the NIH. Between the years 1949 and 1967, the mental health research budget had increased 121.7 times. By way of comparison, the research budget of the National Institute of Dental Research, mental health's nearest competitor in rate of growth, increased 98.7 times over the same period.

By 1967, four years after passage of the Centers Act, the community mental health centers program budget had overtaken the amount of money available for research. Research had not been downgraded as a programmatic priority, nor had research funds been channeled toward the services program. Rather, a leveling of the growth curve that had first been detected in 1964 became more pronounced. The traditional research program and budget, that is, the number of new grants and dollars awarded, became static and other components of the Institute grew around it.

Growth of Targeted Research Programs

Another drain on the NIMH research resource base was itself a function of the Institute's excellent research record of the previous two decades. In 1966 and 1967, a question posed in diverse forms to the entire Federal biomedical research establishment addressed the issue of relevance as it pertained to mission oriented agencies. In a 1967 address at the National Institutes of Health, President Johnson asked whether biomedical research findings and the unprecendented expansion of the biomedical scientific knowledge base, should not be

directly applicable to an improvement of the Nation's health--whether the balance between basic and applied research ought not be reassessed.

The question was indicative of a growing emphasis, felt in all government programs, on the analysis of relative costs versus benefits of programs as a prime criterion for their success and continuation.

However, the benefits of mental health research, while clearly substantial, are not readily demonstrable in quantitative terms. The results of behavioral research often relate to aspects of human functioning--both normal and abnormal--that are less tangible than those dealt with in other health research or service delivery programs. Subsequently, they are less amenable to incorporation in accountability formulae devised by professional administrators far removed from the subtleties of program content.

While calculations can be made of reduced costs resulting from decreasing numbers of Americans hospitalized for mental illnesses, numerical values cannot be attached so readily, for example, to heightened feelings of well-being and strengthened coping capacities, both critically necessary for more productive human functioning.

From my retrospect vantage point today, I can see that these questions of research accountability and public stewardship of public funds had a cutting edge not foreseen in 1967. This cutting edge was unsheathed and fine-honed in a post-Watergate environment pervaded by suspicion of wrong doing by public servants. But it was cast during our critical era, the mid- and late-1960's, and the catalyst was an emerging sense of distrust, not only in the capability of the mental health system but more basically in the goals and idealism of the Great Society.

We were riding, then, on a crest of growing budgets, effortless appropriations victories, and a virtual landslide of legislative changes. Social analysts have termed the phenomena a "revolution of rising expectations." Then, subtly and profoundly, the wave was broken; the obvious obstacles were a growing disillusionment and disenchantment with the Vietnam involvement, urban riots, campus unrest. These and other phenomena broke the motion of the wave and resulted in disappointment, frustration, and anger when the great expectations were not met. It became increasingly clear that the funds to meet the promises were not forthcoming. There was a blend of over-promise on the part of the social architects and, on the part

of the public, an unwillingness to either see the price that had to be paid or to pay the bill. Insidious to overpromising and underdelivery was a doubt in the truthfulness of government. The relationship between lying and overpromising is not simple but it is important and it reduces to the yin and the yang, to trust and distrust in institutions.

Seen in this context, public indignation over Watergate and attachment--at least in rhetoric--to a "post Watergate morality" was not an isolated phenomena but a culmination of complex social processes. Its pertinence in this discussion relates to accountability, trust, and the mission of any given institution or system--here, mental health research. Today we see that those least able to demonstrate quantifiable benefits from funds expended are likely to be regarded not only as sponsors of ineffective programs but as purveyors of dishonest management in government service.

Returning to the 1967 dynamics, it was to the Institute's credit that we were a step ahead of the game when these hard questions began to be asked. At the time of the reorganization, my immediate predecessor, Director Stanley Yolles, had begun to formalize the Institute's expansion into the more targeted area of social problems research. The trend was attuned more to social needs and perceptions than to political demands, and reflected the NIMH's ability to discern voids not only in our knowledge base but in our practical responses to immediate problems of human behavior and development.

For years, NIMH had supported research and demonstration projects on the mental health aspects of various social problems. Growing social and political concern over these problems encouraged the Institute to sharpen its focus by creating special units or centers to deal with such problems. In the mid-1960's centers had been established to coordinate research, training, demonstration, consultation, and communication efforts in nine areas : alcoholism, drug abuse, crime and delinquency, the mental health of children and youth, suicide prevention, schizophrenia, mental health and social problems, metro-metropolitan problems, and epidemiology.

The centers differed in size and responsibility. Some received ongoing projects and grant funds from existing programs in the Institute and were thus able to support projects in addition to their coordinating activities. These were referred to as "operating," "funded," or "total"

centers, and initially were three in number: alcohol, drug abuse, and suicide prevention. The others were "coordinating" centers, without grant money, that stimulated and coordinated support activities throughout the Institute.

Tracking each of these programs from the time of their creation to the present is a task made difficult by repeated reorganization due to changing social needs and priorities. Of the original nine centers, five--alcohol, drug abuse, suicide prevention, crime and delinquency, and mental health of children and youth--formed the nucleus in 1966 of the new Division of Special Mental Health Programs. Schizophrenia, mental health and social problems, and epidemiology were assigned to the Division of Extramural Research; metropolitan problems was situated in the services program prior to its transfer to the Special Mental Health Program in 1969.

In 1971, the Center for Minority Group Mental Health Programs was created as a total center within the special programs division. And the following year, one of the original three funded centers--for Studies of Suicide--was reorganized. Because that particular change is so illustrative of the many factors influencing the course of our special programs, I will take a moment to describe the metamorphosis.

By 1972, it was apparent that the goals and concerns of the Suicide Center were overarching with those of other growing, priority programs such as Minorities and Child and Family. While we recognized the import of the suicide problem, we knew also that we were dealing with a very select population in terms of size. This awareness, combined with the increasingly tight money situation across the Institute led to our decision to allow the Suicide Center to evolve naturally into broader areas of concern that would be receptive to diverse concerns. Also, by disbanding it as a funded center with its demands for a research grant budget, its own IRG, and other ancillary costs, we could in effect create money for other priority areas.

The change was successful; the new Section on Mental Health Emergencies was able to devote staff and energies to coordinating and stimulating research in a variety of areas. And other NIMH components, for example, the Clinical Research Branch's Depression Section, were cooperative in picking up funded projects.

The most recent scenario influencing the direction of the program resulted from passage of the Disaster Relief Act of 1974. Under section 413 of the Act, NIMH was given responsibility for mental health counseling and training, and financial assistance to States and localities in the event of a Presidentially declared disaster. The proposed rules on this program, incidentially, are open to public comment right now.

At any rate, we now have a Section on Disaster Assistance and Mental Health Emergencies. Presently, the funding arrangement is that money is conduited through the Section, with a minimum of red tape, from the Federal Disaster Assistance Administration. This is a prominent development and may warrant in the near future another reevaluation of levels of support of the Section.

Though the various centers have been undeniably effective in stimulating and coordinating such needed creative research, the fiscal ramifications of their existence upon the general mental health research funds were dramatic. This was particularly true of the two centers, alcohol and drug abuse, that later evolved into separate Institutes under the Alcohol, Drug Abuse, and Mental Health Administration.

In 1970, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act mandated the creation of a National Institute on Alcohol Abuse and Alcoholism. The Center for Studies of Narcotic Addiction and Drug Abuse was elevated first to Division status within the NIMH and then, under the Drug Abuse and Treatment Act of 1972, was mandated to be a separate Institute by 1974.

In 1972, the Division of Special Mental Health Programs spent $8.5 million on research grants, out of an Institute total of $82.5 million for all research grants. That same year, the units concerned with drug abuse and alcoholism spent $19.5 million, more than twice that of the Division they had sprung from. As a further illustration of the tremendous growth of public and governmental interest in these areas, research grants for the two areas accounted for only 10 percent of the Institute's research grant funds in 1968, but close to 25 percent just four years later, in 1972.

III. THE SHRINKING DOLLAR: 1967 - 1977.

The foregoing discussion provides some flavor of the forces at work over the past decade to reduce both the potency and availability of the NIMH research dollar. This section of the paper will present some of the hard data that supports and even dramatizes the critical nature of these changes.

Without intending invidious comparisons, we are able to illustrate a very dramatic trend simply by holding up NIMH/ADAMHA budgets against NIH budgets for the same decade.

In 1967, the research budget for all components of NIMH was $103,837,000. Today, excluding research activities in alcohol and drug abuse, the NIMH research budget is $95,908,000. The decade resulted in a 7.6 percent decline in actual budget dollars available.

In 1967, the total research budget for all components of NIH was $588,819,000. The Administration proposal for 1977 is $2.14 billion, change that reflects a 263 percent increase in actual dollars. (Fig. 1)

Because any comparison of the two agencies involves so many factors, figures, and trends, however, it may be more illustrative to focus down on specific aspects of the entire picture.

When we look at budgets in terms of actual dollars available, we lose sight of perhaps the most telling trend over the decade. This is inflation; we cannot purchase the same goods and services with a 1977 dollar as were purchased with a 1967 dollar. For these analyses, we have used the "NIH Biomedical Research Deflator," a constant that accounts for the annual, average 7.2 percent rate of inflation between 1965 and 1975. Thus, we are able to see:

Between 1969 and 1975, funds for the research programs of NIH increased by more than 34 percent in terms of actual buying power; at the same time, comparable support for mental health research decreased by nearly 31 percent. (Fig. 2)

A comparison of the budgetary fate of NIMH even with those Institutes of NIH that have also suffered decreases demonstrates how seriously the NIMH position has eroded. Taking inflation into account, four of the 10 Institutes of NIH have experienced reductions

in grant support ranging from 8 percent (National Institute of Allergy and Infectious Diseases) to 22 percent (National Institute of Neurological and Communicative Diseases and Stroke) since 1969. None of these approached the 31 percent reduction of NIMH research funds. And as a side observation, it is fascinating to note that NINCDS and NIMH--the two brain-related Institutes--are the two hardest hit. (Fig. 3)

Of all NIH and ADAMHA Institutes, NIMH, and to a lesser degree, NIAAA, were the only ones to suffer a cut in actual research obligations over the years 1970 to 1975. (Fig. 4)

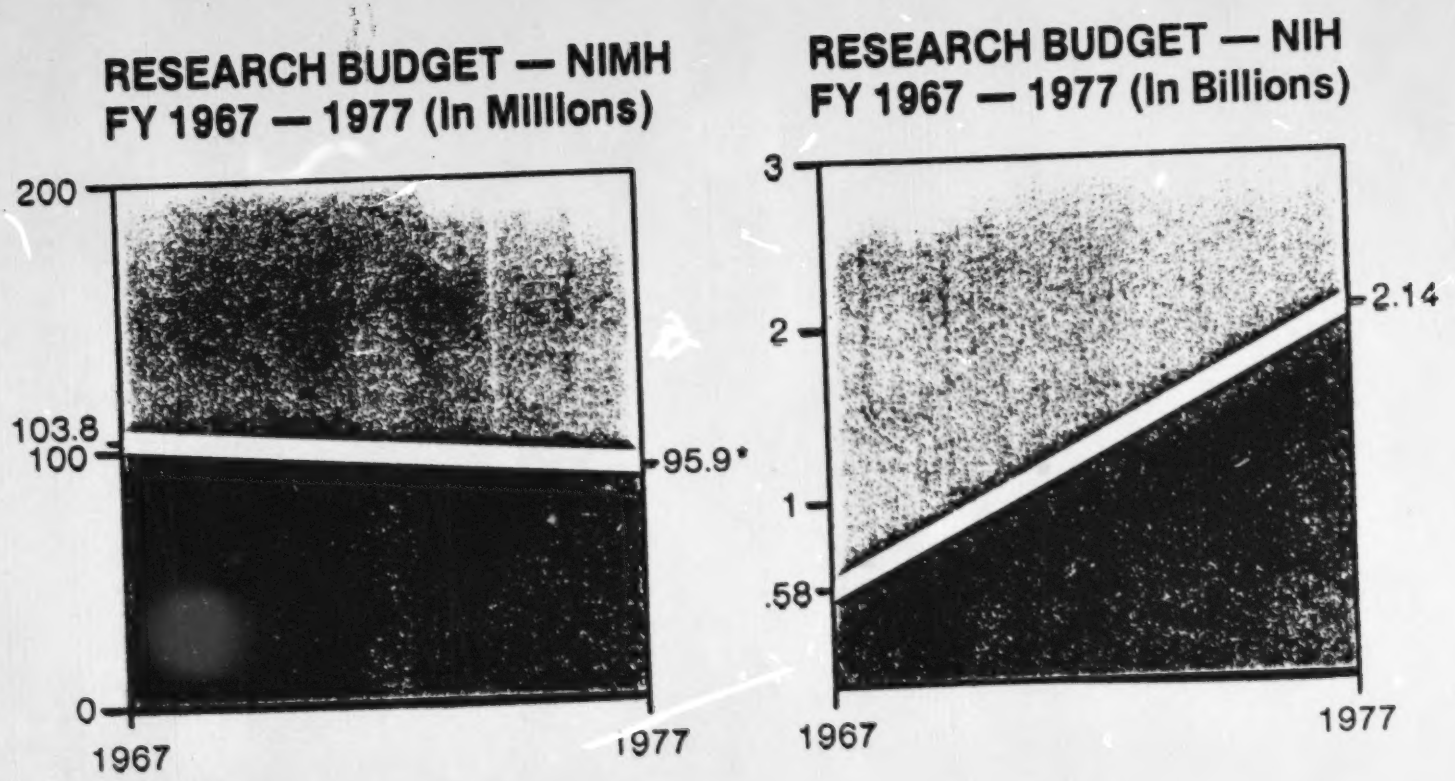
The Institute's 1976 budget allocates $62 million dollars for research grants--$18.7 million less than in 1967, or a reduction of more than 23 percent. Employing the constant dollar figure, that cut translates into a 53 percent decrease in buying power. (Fig. 5)

The view ahead is even more ominous. The 1977 budget allocates $60.1 million for the research grant program--a decline of $20.6 million, or 25 percent, over the last decade. Further incursions of inflation will mean an actual cutback of $45.1 million between 1967 and 1977, a total of more than 56 percent. (Fig. 6)

These data tell a devastating story: Over the past decade, more than half of the NIMH research grant support capability has been erased.

In comparison to its sister Institutes within ADAMHA, support of mental health research has been reduced in remarkable disproportion. In 1970, research obligations for drug abuse totaled $5.3 million; by 1975, the research budget of NIDA had risen to $34 million--an increase of 642 percent, a full one and one-half times the percentage increase of the National Cancer Institute. The National Institute on Alcohol Abuse and Alcoholism, even without a heavy programmatic emphasis on research, enjoyed an increase from $5.3 million in 1970 to $11 million in 1975, a 208 percent increase.

Recall that the dominant characteristic of the period under discussion is the departure of NIMH from NIH. In comparing the fiscal fates of the two agencies, it is interesting to note that the ramifications of that split are being felt directly more than a decade later. This fiscal year a $130 million dollar supplemental appropriation was provided to NIH by the Congress in an attempt to



*Excludes NIDA and NIAAA

- NIMH BUDGET DECREASE: 7.6%
- NIH BUDGET INCREASE: 263%

Fig. 1

Research Grant Support to NIH and NIMH (Buying Power 1969-1975)

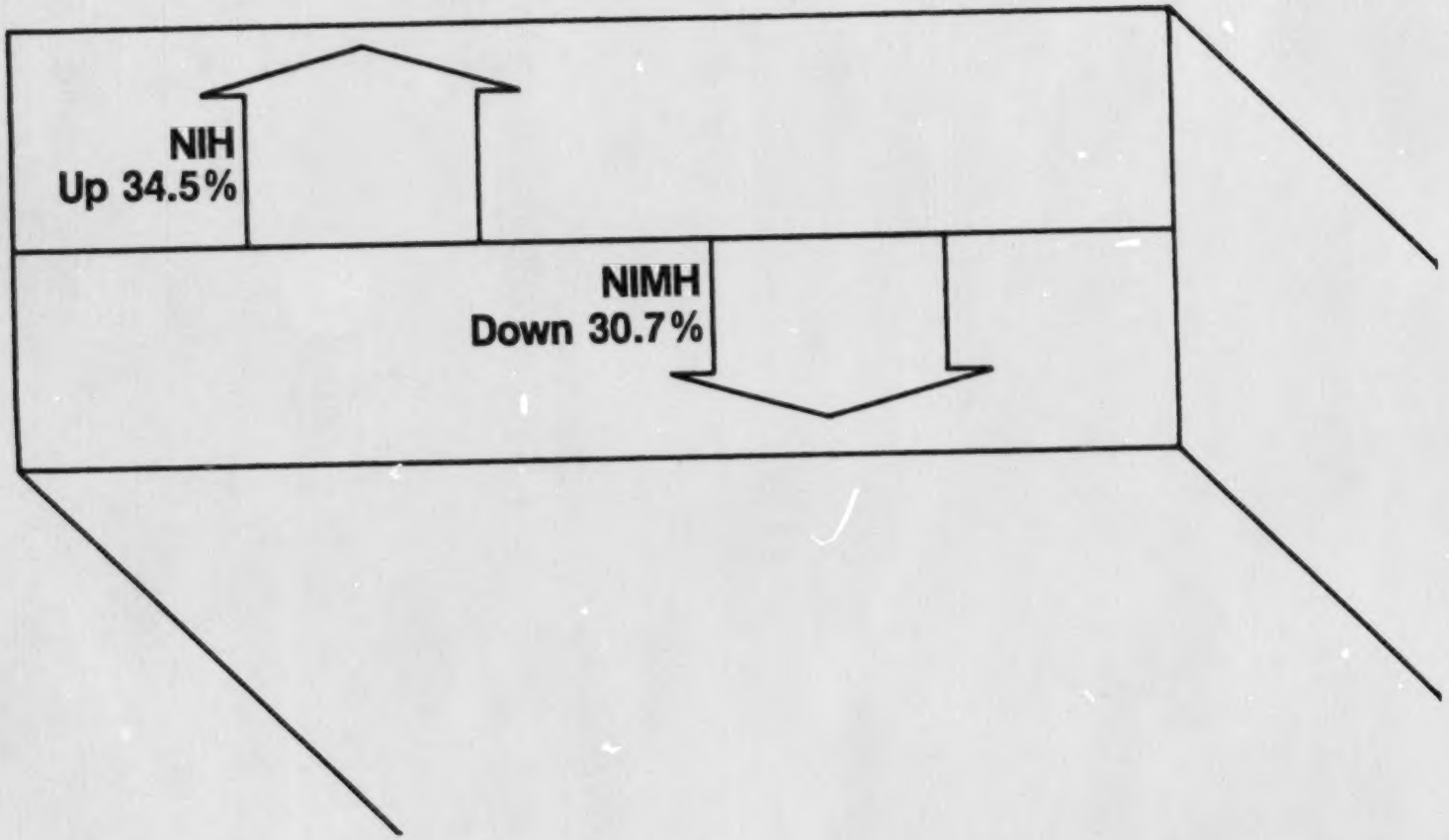


Fig. 2

Decreases in Support of Five Health Research Institutes (Buying Power 1969-1975)

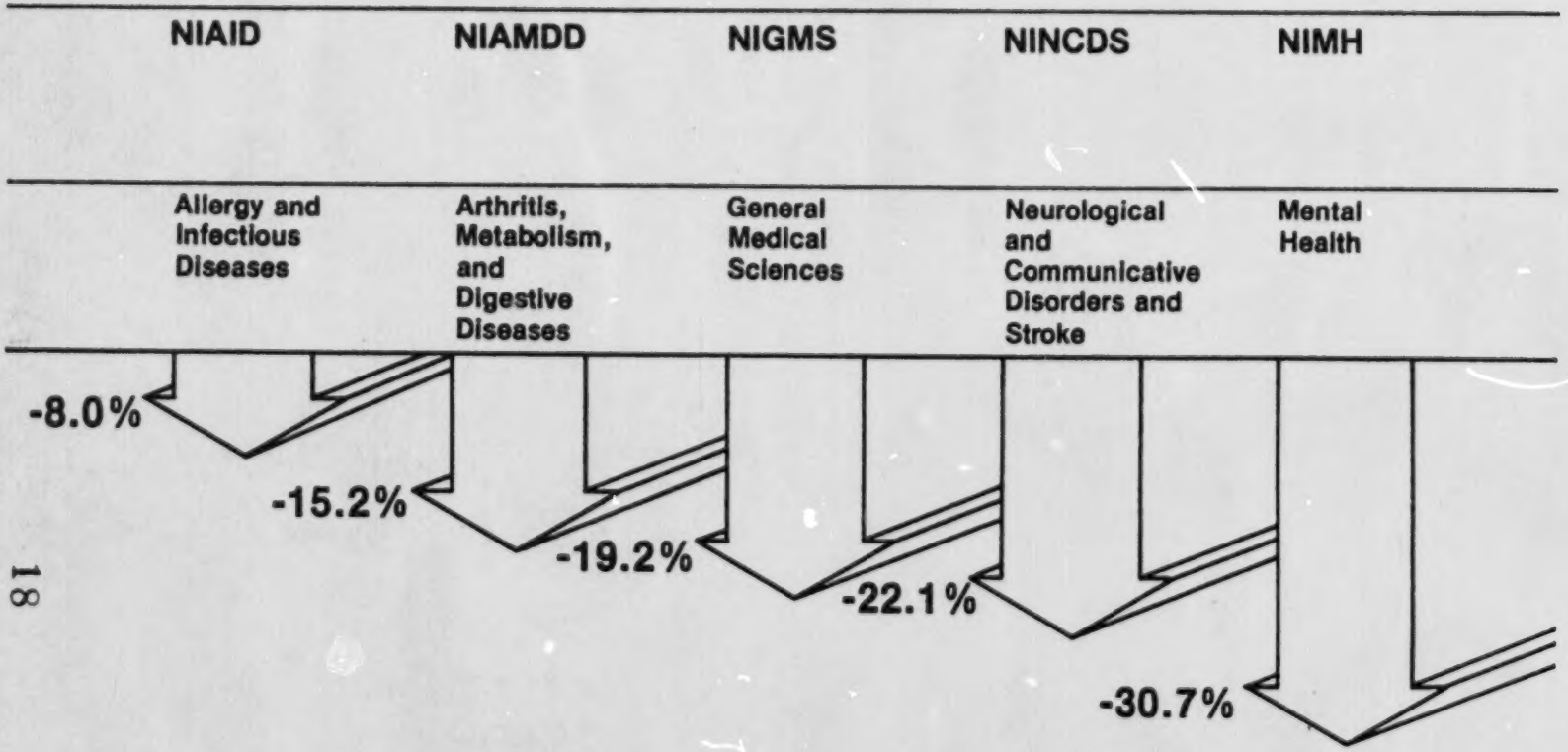


Fig. 3

COMPARISON OF RESEARCH OBLIGATIONS:

- NIH INSTITUTES
- ADAMHA INSTITUTES

1970 – 1975

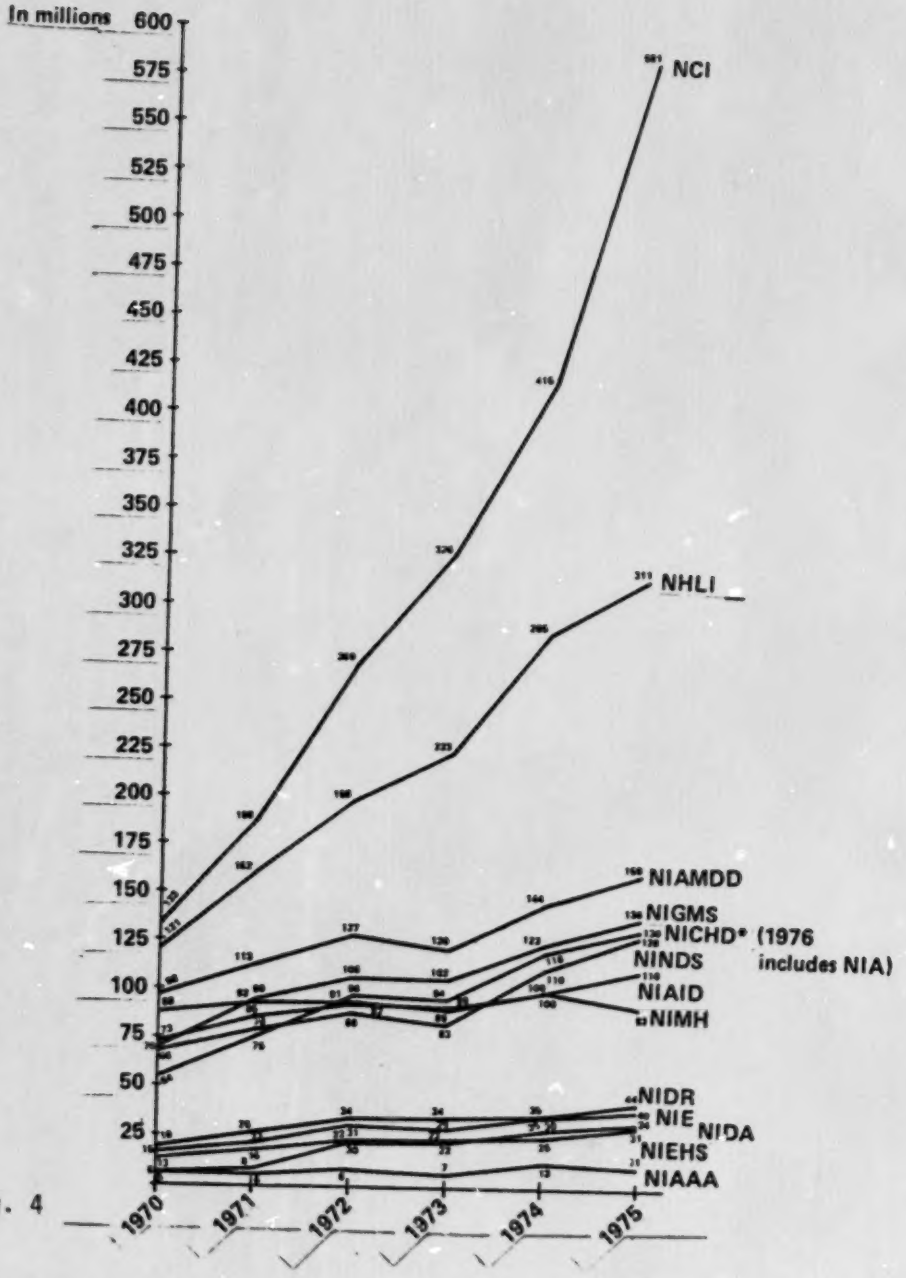


Fig. 4

Decline in Mental Health Research Grant Support (1967-1976)

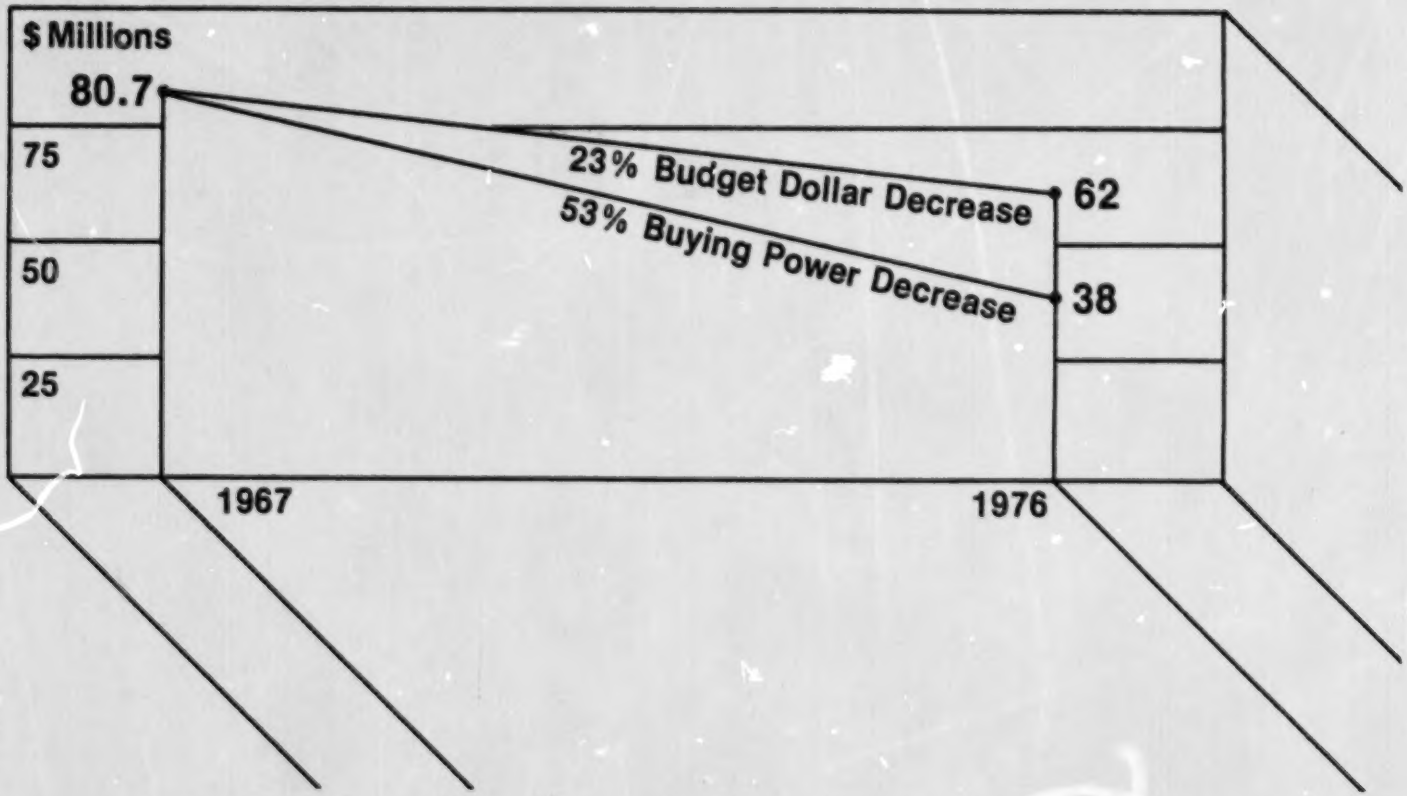
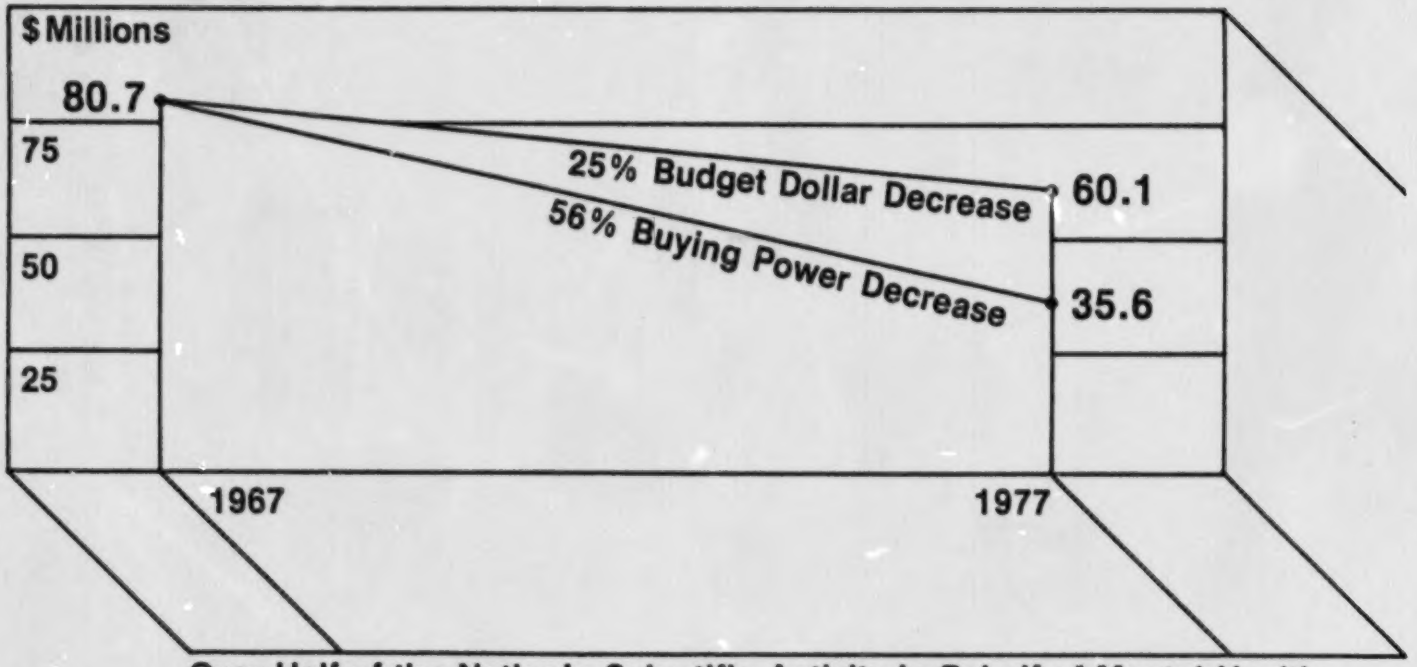


Fig. 5

Decline in Mental Health Research Grant Support (1967-1977)



Over Half of the Nation's Scientific Activity in Behalf of Mental Health has been Erased.

Fig. 6

balance out the differential between the "superendowed" Institutes--Cancer and Heart and Lung--and other components of the NIH. Despite the best efforts of ADAMHA Administrator, Jim Isbister, NIMH, the most drastically cut of all the Federal biomedical programs, was unable to obtain a portion of that supplemental.

Recognition of the Problem

As the data indicates, the decline has been accelerating for nearly the entire period of analysis. Were we unaware of it? Why the sudden realization of a critical state?

In large measure, the most dramatic aspects of the situation have gone relatively unnoticed. Though the NIMH general mental health research budget had already begun to plateau by the mid- to late-1960's, the strongly politicized and socially sensitive drug abuse and alcohol programs were only coming into their peak years in 1970. As described above, the growth of these programs in subsequent years helped camouflage cutbacks in general mental health.

Upon the creation of ADAMHA in 1973, the research budget was broken down into separate allocations for each of the three Institutes. The ability of the parent Institute, NIMH, to distribute funds to program areas of greatest need--limited regardless because of obligations, earmarked funds, and Congressional mandate--was eliminated totally. The state of the general mental health research budget had to be viewed under a harsh new light.

Also, the NIMH program planners had not routinely assessed the effect of inflation, or, more precisely, the combined effect of declining research purchasing power and increasing research costs. It is this analysis that most dramatically illustrates the drastic downward slope of what otherwise has been considered a plateau--a plateau that has been reached with few exceptions by the entire Federal biomedical research establishment.

The Concomitants of Fiscal Strangulation

The deleterious effect to a National research program that directs the bulk of its resources to investigator initiated projects in the private sector can be measured only in part by loss in dollars and number of awards. The impact to the mission of the NIMH can be assessed clearly, if less quantitatively, in terms of what I define as concomitant factors.

If less dollars for research meant simply that a limited number of projects temporarily tighten their belts to resume again at full pace when the storm passed, we would not be speaking of a crisis. The hidden nature of the crisis is found in the administrative and qualitative threats to our "tenuous enterprise;" these threats merit separate consideration.

The shortened life span of research grants: During recent years, the uncertainty of budget allocations and the anticipation by research managers of continuing decreased resources have led to a decision by the Institute to shorten the commitment period of research grant funds. In the past five years, the average life span of an NIMH research grant has been reduced from five years to three. Underlying this decision was the recognition that funds previously commited to long-term projects would become available to support new or competing grant proposals. Moreover, additional and more intensive review of research in progress could be accomplished, we reasoned.

The actual results of this administrative tactic have been disappointing. Although it would appear that the NIMH has increased funds available either for new grants or for competing renewals, the appearance is an illusion; the total number of available research dollars is decreasing and shorter grants yield no additional options when completed. Further, shorter research projects appear to be regarded less by review committees than are long-term projects--the decision may be leading toward poorer research.

Loss of NIMH control and flexibility in planning: A strategy taken by the Office of Management and Budget in recent years, and particularly apparent in fiscal years 1976 - 1977, has considerably weakened the Institute's control over its own financial destiny. When there is a decrease in research commitments--as might be attained through the Institute policy described above--the OMB attempts to maintain a level amount of "free money," that is, unobligated funds. When there is an increase in free money, OMB holds NIMH level on the total amount of the budget. The free money available to the Division of Extramural Research Programs in fiscal 1976 is the smallest amount ever. This figure is being used by OMB in determining the amount to be available in fiscal 1977.

Morale and operational efficiency of research administrators: A traditional role of Federal health research administrators has been to

consult with research applicants. Such consultation has enhanced the quality of research protocols as well as the probability of approval. In the face of research cutbacks, a decreasing administrative staff is required to provide all applicants equal access to consultation and review. But those same applicants face a greatly reduced likelihood of funding. If NIMH staff efforts were directed toward grants with the highest chances of approval, however, we would in effect be screening applications and thus destroying the peer review system.

Loss of credibility with the research community: Continuing budgetary uncertainties and administrative stumbling blocks are weakening the sense of trust in the NIMH long felt and expressed by the research community. Increasingly, the Institute is seen as adversary rather than as advocate and colleague of the research scientist.

Loss of today's competent researchers: When grant awards are delayed for considerable periods, investigators must commit themselves to matters other than research--for example, to teaching. This may have been a policy intent of OMB. Repeated and protracted postponements in grant awards makes it difficult even for the most talented researchers to commit time and energy to the grant application and negotiation process.

Loss of investigators and laboratories of the future: The steady attrition of NIMH support promises to have a significantly damaging impact on the future course of mental health research. The long range impact of the current crisis may include the absence of experienced researchers tomorrow who should be launching careers today. Also, a shortage of laboratories exists and may block the need to commit resources to critically needed research programs in future years.

IV. DYNAMICS OF THE DECLINE

In the earlier discussion of events which led up to the 1967 reorganization, the major dynamics were described which pose continuing threats today to NIMH research activities. Yet in the late 1960's these programmatic realignments were for the most part viewed as developments necessary and beneficial to the evolution of the Institute and its mission.

A decade later we do not regret these changes. Progress made by this Institute on behalf of the mentally ill has been encouraging,

more so in light of social and political stresses that have characterized every aspect of American life during this period. Against odds that have at times been overwhelming, the community mental health program has stood its ground. The 603 centers that have been funded in all 50 States, the territories, and the District of Columbia make accessible comprehensive and continuing mental health treatment to more than 87 million citizens. For the first time in the history of the State and County mental hospital system, we have obtained a one-to-one staff patient ratio. The proven need for and the efficacy of the mental health service system have made psychiatric coverage under National Health Insurance a certainty.

Nevertheless, as we have seen, some of these same forces and dynamics have had a negative effect on research activity. In order to deal with the crisis, we must attempt to fully appreciate the dynamics of the decline.

The Battle of the Holy Triad

The first major dynamic involves what I have termed here the "holy triad"--the three legged research, training, and service structure of NIMH. In this context, that is focusing on research, I find it convenient to condense the triad into a diad, lumping together mental health services and training. The name for this cluster, in other arenas, is called resource development. These latter programs, over the years, have developed their own constituencies and bases of support that, while admittedly coping with their own urgent and critical concerns, have often demonstrated a minimal interest in research matters.

Some analysts of the mental health program hold that as a consequence of maintaining programs in all three areas, NIMH has undermined its research support base. Varying claims are made that:

1) The Institute lost its research ethos with the split from NIH;

2) The insatiable demands of the service dollar have driven down and out the research dollar: and

3) The demands for leadership of such a complex enterprise may have diluted the concentrated leadership and attention vital to the research sphere.

Of these three broad allegations, I personally feel that the last may be the most valid.

Another dynamic or force contributing to declining research support, stems from and is inherent to the existance of the holy triad.

The Administrative/Organizational Change Dynamic

Overlapping, and in many ways synonymous to the "battle of the holy triad," has been the hard, often-repeated question: To separate or not to separate? The three legs of the NIMH since its inception have been research, training, and services. From the earliest days of NIMH, this convergence of the three spokes of the triad represented the social movement called mental health. The triad was able to bring together such diverse pursuits as bench research on the one hand, to services through technical assistance to the States on the other.

An historical note: shortly after Dr. Felix was appointed director of the old PHS Division of Mental Hygiene in 1944, he submitted a 21 page draft program to the Surgeon General. Entitled "Outline of a Comprehensive Community-Based Mental Health Program," the proposal did in fact form the rough basis of the National Mental Health Act. Even then it is significant to note that while the House and Senate bills were introduced as the National Neuropsychiatric Institute Act, the legislation passed under the name we know -- the National Mental Health Act and led to creation of the NIMH.

The question of whether this unusual constellation of research, training, and service could survive in a health bureaucracy that traditionally separated these functions fast became an issue. A major reorganization proposal in 1959 - 1960 would have left research as part of NIH, moved services to the Bureau of State Services, and training programs to yet a third organization. In what is now hailed as a classic defense in public administration literature Dr. Felix resisted the proposal. The battle has flared again and again--in 1965, 1966, 1971, 1974, and up to the present.

It may be convenient again to peg 1967 as a critical moment in analyzing the managerial issues surrounding the triad. Despite the fact that NIMH had grown up as an aberrant Institute within the NIH because of its composition, it grew faster than did the NIH, broke off and became a coequal agency. This was a symbolic turning point, where NIMH was no longer seen strictly or primarily as a research enterprise but as something special and on its own. Since then it has wandered in a bureaucratic wilderness, falling under HSMHA, then NIH briefly again, then ADAMHA, but has never lost its triadic identity.

The latest bulletin, in just last week, shows that the vote of the President's Panel on Biomedical and Behavioral Research--which also took its turn at the reorganization shuffle--was 4 to 3 against splitting up the Holy Triad. The next act remains to be played.

Because we have come through all this intact should not minimize the strain placed on the NIMH organization. In retrospect, all of this may be viewed as a series of administrative changes; in our day to day operations, administrative chaos would often have been a more natural term.

The Social Sensitivity Dynamic

Since the early days of technical assistance to the States, one of the unique and controversial roles of the NIMH has been as a nexus of the scientific research establishment and a constantly changing spectrum of social concerns. Often, the involvement has been sought and initiated by the Institute in response to perceived social needs: other times the involvement has been forced upon the Institute, with either our receptivity or at times some resistance. Whatever the origin and route of a topical behavioral concern, NIMH traditionally has been the terminus. This level of responsiveness is correlated closely to an institutional social sensitivity. One illustrative case that I am proud to highlight was the establishment in 1971 of the Center for Minority Group Mental Health Programs--one of my first acts upon becoming director of the NIMH.

Under Title V of the 1956 legislation, the Institute provided research support in special problem areas such as mental retardation, alcoholism, drug abuse, aging and other areas. These special projects were well received and by 1964, nearly 300 grants totaling some $16 million dollars were awarded in these areas.

Between 1964 and 1968, while the growth rate of the Institute research program began to show signs of leveling, the responsibilities of the Institute increased. This was the area of the Great Society's attack on poverty, crime, urban problems, drug addiction, and alcoholism. NIMH, with its record of research activities on such problems, was encouraged to create special units or centers. In a serendipitous instance of the right Director at the right time, Stanley F. Yolles, who had succeeded Dr. Felix in 1964, strongly supported the center concept.

As I described previously, nine special programs were set up, leading to the formation of the Division of Special Mental Health Programs. Where the centers were anticipatory, and nurtured by the proper blend of social and political interests, they thrived and had vast consequences, with alcohol and drugs becoming Institutes. In other cases, the centers have not grown into separate programs but have metamorphosized naturally into other programs: for example, as I have described, the Center for Studies of Suicide.

And the programs are still emerging and evolving as the need is felt. Research on mental health and aging, one of the most durable of Institute special interest areas only recently was elevated to Center status. Today, aging enjoys a broad base of support in the health arena, with political awareness of the issue growing, and with an increasingly active and vocal consumers' movement. The NIMH Center for Studies of Mental Health and Aging promises to be a major influence on the course and productivity of research in this field--barring, of course, a prolongation of the research crisis.

Still other problems, the "lightning rod" problems, often expensive and time-consuming, have been laid on our doorstep by special Congressional action. The effects of television violence on social behavior, particularly of children, and attendant questions of learning and development is one example. It is a research topic that will form the basis for a society-wide debate that may entail such volatile issues as control and regulation of the industry and so forth. While the whole question might be politically risky, our best contribution is to support scientifically rigorous and uncompromised research.

The Institute was given the responsibility this year to establish a National Center for the Prevention and Control of Rape. Again, an outgrowth of political pressure and our unique ability to contribute to an understanding of the social bases of behavior. With a $3 million operations budget appropriated, but relying at present on the capabilities of staff already on board, the evolution and progress of this Center is of critical concern - an important experiment.

There are those who contest this expansion into the social issues arena. The arguments are familiar to all of us and involve the perennial debates of basic versus applied research, investigator-initiated versus targeted research, and biological versus psychosocial research.

The Institute is criticized for supporting social problems research at the expense of biomedical and behavioral research. This may be true in part, and I qualify that purposefully. The point is that the interest or emphasis on social issues is a dynamic of the present situation, a function of the times that we must recognize and work to our best advantage.

My reason for qualifying the answer above is simply that if we compare today's research balance with that of 20 years ago, we are comparing today's apples and oranges with yesterday's apples, That is, if we limit our analysis to the core research on mental illness that comprised the bulk of the research program originally, we see a slight trend toward biological studies and only a slight shift of resources from the basic to the clinical, applied sphere.

Much of the money now being funneled toward social problems research is money that came available specifically for that purpose; thus the claim that these activities are eating from the biomedical and behavioral trough is arguable.

Anti-Psychiatry/Anti-Mental Health Dynamic

During the entire period of its existence, NIMH has been beset by a host of forces which, from varying perspectives, have attacked the validity, sanity -- even the Americanism -- of the mental health movement. These forces arise from within as well as from outside the mental health community. Although all fields of science are marked by substantive and theoretical quarrels, the past few years have witnessed unusually strong dissension in psychiatry and the mental health field as a whole. Some psychiatrists, for example, have been proclaiming with conviction that "psychiatry is dead," or that "mental illness is a myth," while many lay persons have attacked the entire field as devoted to "brainwashing" and mind control rather than to healing.

Meanwhile, of course, the field of mental health has suffered in common with the other research areas from the anti-intellectual faces that chronically attack the entire research community as remote from the day-to-day needs of real people in their functioning environment.

The Growth of Anti-Science

The golden era of the scientist appears, at least temporarily, ended. The physical sciences have been under attack since the time

of Hiroshima; the biological and life sciences are now being called to ethical account in matters of genetics and other life-manipulating matters. The psychiatric and psychological sciences are viewed by many as the most threatening and frightening of all, dealing with mind control, behavior modification, lobotomies, psychiatric drugs -- all ways to manipulate others. No doubt some of these fears are justified. Scientists and those who use the results of science have been known to engage in loathsome acts and heinous crimes; recent history is rife with examples, and the sophistication of modern psychiatric technologies in the absence of ethical and humanistic social concern, represents a potent and tangible threat. Mental health research has unfortunately suffered from attitudes engendered by these realities.

Despite heroic efforts during the past quarter-century to reduce the stigma attached to mental illness, public perception of the mentally ill continues to be significantly clouded as well with shame, suspicion, and hostility. American towns continue to pass ordinances designed to exclude those who have been treated in a mental hospital; middle-class neighbors fear their property values will erode if a halfway house or boarding home for former patients were to be opened down the block; and people will talk openly about a heart attack or surgery for cancer, but still keep secret their depression or that of a family member.

The image of mental health research -- its respectability and worth -- undoubtedly suffers also because the very beneficiaries of its efforts, are, themselves, suspect. Troubled people, many believe (including many in positions of influence and power), need most to develop self-control and discipline, even to be punished, but certainly not helped. Mental health problems are for many fiction, a convenient rationalization for those who would pamper the "morally decayed" or the "ethically flawed" among us. If the goal of mental health is devalued or rejected, so, too, is the mental health research community and the Federal institution that serves its purposes.

The subject matter of mental health research often includes areas tinged with strong emotions -- human sexual behavior, death, aggression, and many more. For many Americans, such human experiences ought not to be the subject matter of laboratory scientists. In their minds, these are areas of behavior that are either too sacred or too profane to be analyzed by scientists by public funds. The persistence of biomedical and behavioral scientists in pursuing such variables as legitimate areas of research engenders a hostile

attitude, not only among segments of the public, but also among many in positions of influence in both the political arena and the media.

Despite the overriding importance of protecting the rights and integrity of research subjects on ethical, moral, and legal grounds, it appears that mental health research may be particularly and idiosyncratically vulnerable to recent concerns about research with human subjects. Regulations have been proposed that could seriously hinder the study of mental patients, children, prisoners, the aged, and many other groups.

An unfortunate concomitant of the activities surrounding the formulation of current regulations is the wide publicity given those few projects which appear to have challenged the rights of experimental subjects -- research having cruel, coercive or manipulative overtones. The unfortunate result is that public support for mental health research is tempered by a misperception of the field as a whole.

Because the subject matter of mental health research often deals with aspects of human behavior with which everyone is familiar, many regard it as wasteful to support their study. In the arena of human behavior, everyone, it seems, is an "expert." The nature of love, the roots of behavior problems, the causes of insomnia, the role of the family -- these are aspects of the human experience with which we are all familiar. So are we also exposed in our everyday lives to neurotic behavior, to fears and phobias, alcoholism, depression -- problems whose solutions, many believe, can be derived from common sense and "will power" rather than scientific inquiry. No such identification with research subject matter is made by the public or its leaders where, for example, the nature of the nervous or circulatory systems, or the etiology of malignant cells or clogged arteries are concerned.

V. IMPLICATIONS AND DISCUSSION

This presentation has attempted to illuminate the crisis of support currently being experienced by the research programs of the NIMH. Such a retrospective analysis shows many critical events, some originating in the Institute's earliest days, that have contributed to the current situation. Portions of this assessment of the dynamics admittedly is soft data; the hard data, however, the dollars and percentages, leaves little question as to the current status of the NIMH research program.

The Holy Triad's Moment of Truth

It appears that for the present, with the vote of the President's Panel in, the three way structure of the Institute is temporarily stable. But a continued depletion of mental health research resources poses even a greater threat to the unfinished agenda of the NIMH. Further cutbacks are intolerable. With a knowledgeable appreciation of the state-of-our-art and the scope of the field, it is reasonable to say that development of the mental health knowledge base is yet in its incipient stages. Relative to other biomedical research endeavors, mental health lags. To remain accountable to our mission, we obviously must do at least as well in the competition for resources as the "poorest" NIH component. As we have seen, NIMH falls short even of that minimal prerequisite by 8 percent in relative buying power.

Hopeful Factors on the Current Scene

The NIMH Research Task Force was initiated before already bleak trends in the research program had assumed the shape of a crisis. Consequently, the report Research in the Service of Mental Health has proven itself a tremendously timely and useful document. It is a rich resource in the substantive concerns of the research scientist and administrator: Where are we now and where do we go from here?

The Task Force addressed administrative concerns as well; some recommendations, already implemented, have been exciting and successful. One of these was the concept of the Research Advisory Group to the Director. RAG brings together the key people, from bench scientist to program administrator, for a weekly, no holds barred analysis of research issues.

One dramatic product of the RAG deliberations this year was the inclusion, in the HEW Forward Plan for Health, of a substantial increase in the mental health research budget. The Forward Plan proposed $105 million; that has been reduced by the Office of Management and Budget to $83 million, but it still gives grounds for optimism.

Another reason for optimism is that while the full report of the President's Panel is not yet complete, we do know that the panel will recommend an increase in the level of mental health research support.

Indeed, the very fact of this presentation represents an unprecedented mobilization and translation of thought and rhetoric into action. We have broken the inertia. What steps should be taken?

Breaking the Boundaries

Too often, until a scientist's own application is not funded, he or she remains unaware of and detached from the politics of health research. As a result, scientists have been ineffective in seeking support for and fostering mental health research. Many scientists remain naive about governmental processes, believing that an editorial in Science or a letter to their Congressman will prove sufficiently effective. Few scientific groups work to their political advantage at a local level. Few know their local congressman or, more important, how to reach the constituent power base behind the congressman.

This power base, the "lay public" as we call non-researchers, is the silent majority of science. They support or do not support research. They stand to benefit from its successes, but they also are often the most vulnerable to misconceptions about the purpose and process of science research.

Our foremost need in an era of increasing competition for scarce research resources is public support. The public has to make a committed and informed decision as to whether or not it will support mental health research needs.

Neither the scientific community nor the public can pull it off alone. The comfortable blanket of Federal support for all biomedical research has been pulled, and a new cooperative effort is necessary.

One hopeful development is that citizen groups such as the 1 million member National Association for Mental Health that have been and are effective in engendering support for mental health services are now aware of the research crisis and have begun to put their efforts behind support of the research component of the National mental health effort.

VI. A SOCIAL AND HISTORICAL POLICY PERSPECTIVE

The current crisis is as much a crisis of understanding as it is a crisis of declining research support. In my estimation, it was the NIMH research base and two solid decades of NIMH research experience and prestige that led to the success of the community mental health centers program.

As we have seen in this paper, one of the most hotly debated issues surrounding the support of research by NIMH involves the question of the impact of the Institute's support of non-research programs--services and training--on the research programs themselves.

On the one hand, some have argued that were it not for the visibility of the NIMH's socially oriented programs and their strong service delivery orientation, NIMH research as a whole would have suffered more. Research, the argument suggests, was the beneficiary of the NIMH investment in visible and politically appealing programs.

On the other hand, there are those who argue that the initiation of service activities and related manpower production efforts drained the research programs of needed growth resources. Here, research, instead of being the favored child, is viewed as the outcast of the three sibling NIMH family.

It may be true that the community mental health centers would not have been as successful as they have if they did not gain sustenance from the research base. Conversely, if it were not for the centers' role in defining the needs of the mentally ill patient, we would not be as far along the path to practical understanding and effective treatment of the major mental illnesses.

Perhaps the question cannot be adequately resolved without a controlled study of an NIMH evolution over thirty years in which the functions of research, training, and services have been separated. That being a rhetorical proposition, we are left to rely on our professional wisdom and judgment what effect the triadic structure had had on our ability to meet mental health needs of the Nation.

Very briefly, I would say that the existing set-up has provided the National program with a measure of coordination that might not have been attained otherwise. In numerous ways, it would appear that the structure helped effect and facilitate the "technology transfer" from research to service.

Early on, the Biometry Program and later, the Center for Epidemiologic Studies in conjunction with Biometry, provided sophisticated monitoring of mental health service, manpower, and knowledge needs, making this information readily available to the research components of the Institute.

Through the Technical Assistance Project (TAP) mechanism, the Institute was able to convene researchers, practitioners, and State mental health staff in workshops or seminars focusing on a specific mental health problem. Along the same lines, in 1962 the old Community Services Branch initiated a series of Research Utilization Conferences that brought together the same ranges of expertise to discuss mental health program areas requiring special attention. The goal of the conferences was to translate research findings into operating programs.

Where we would be without these various efforts is perhaps unanswerable. However, the opposite side of the issue was illustrated last fall during discussions between the President's Panel on Biomedical Research and the administrators of the National Cancer Institute. Dr. Frank Rauscher told the panel that Congressional mandates for that Institute in the area of patient care were draining research resources as well as the attention of scientists away from basic research into the causes of cancer. In order to demonstrate the products of its research, the Panel was told the NCI is providing seed money to start up local cancer control programs that emphasize early diagnosis, treatment, and continuing care.

This example is not conclusive, of course, though it does indicate an expression of similar criticisms by those who would argue for separation of the research programs.

Summary

The present mental health research crisis is not merely an economic or administrative debate, the resolution of which will entail either a recouping of research resources or a downgrading of research in isolation. As I have attempted to suggest, it is our belief that the decline in research support, with all its contributing dynamics, is hinged to the cohesiveness and success of the total mental health program in this country.

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